MEDICARE SUPPLEMENTS
Preliminary copy

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6.6.501 DISCLOSURE STATEMENTS IN SALE OF MEDICARE SUPPLEMENTS INFORMATION TO BE FURNISHED PROSPECTIVE INSURED (REPEALED) (History: 33-1-313, MCA; IMP, 33-18-204, MCA; NEW, 1978 MAR p. 1610, Eff. 6/1/79; REP, 1981 MAR p. 1474, Eff. 2/1/82.)

6.6.502 PURPOSE (REPEALED) (History: 33-1-313, MCA; IMP, 33-22-902, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.502A PURPOSE (1) The purpose of this subchapter is to:
(a) provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;
(b) facilitate public understanding and comparison of such policies;
(c) eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and
(d) provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare. (History: 33-1-313, MCA; IMP, 33-22-902, MCA; NEW, 2004 MAR p. 313, Eff. 2/13/04.)

6.6.503 APPLICABILITY AND SCOPE (1) Except as otherwise specifically provided in ARM 6.6.507, 6.6.507C, 6.6.508, 6.6.509, 6.6.515 and 6.6.521, this subchapter shall apply to:
(a) all Medicare supplement policies delivered or issued for delivery in this state on or after February 1, 1982, the effective date of this subchapter; and
(b) all certificates issued under group Medicare supplement policies which have been delivered or issued for delivery in this state.
(2) This subchapter does not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations. (History: 33-1-313, 33-22-904, MCA; IMP, 33-22-904, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04.)

6.6.504 DEFINITIONS For purposes of this subchapter, the terms defined in 33-22-903, MCA, will have the same meaning in this subchapter unless clearly designated otherwise. The following definitions are in addition to those in 33-22-903, MCA.

(1) "Bankruptcy" means when a Medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(2) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days. The 63-day period shall be counted as described in 33-22-141 and 33-22-142, MCA.

(3) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) a group health plan;

(b) health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

(e) chapter 55 of Title 10 USC (CHAMPUS);

(f) a medical care program of the Indian health service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under chapter 89 of Title 5 USC (Federal Employees Health Benefits Program);

(i) a public health plan as defined in federal regulation; and

(j) a health benefit plan under section 5(e) of the Peace Corps Act (22 USC 2504(e)).

(4) "Creditable coverage" shall not include one or more, or any combination of the following:

(a) coverage only for accident or disability income insurance, or any combination;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; and

(h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(5) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) limited scope dental or vision benefits;

(b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of; and

(c) such other similar, limited benefits as are specified in federal regulations.

(6) "Creditable coverage" may not include the following benefits if offered as independent, noncoordinated benefits:

(a) coverage only for a specified disease or illness; and

(b) hospital indemnity or other fixed indemnity insurance.

(7) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and

(c) similar supplemental coverage provided to coverage under a group health plan.

(8) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 USC section 1002 (Employee Retirement Income Security Act).

(9) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(10) "Medicare advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 USC 1395w-28(b)(1), and includes:

(a) coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(b) medical savings account plans coupled with a contribution into a Medicare advantage plan medical savings account; and

(c) Medicare advantage private fee-for-service plans.

(11) "Medicare supplement policy" has the meaning provided for in 33-22-903, MCA, except that "Medicare supplement policy" does not include Medicare advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act. Policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare advantage plans (established under Medicare Part C) must comply with the Medicare supplement requirements contained in Montana administrative rule and statute.

(12) "Pre-standardized Medicare supplement benefit plan," "pre-standardized benefit plan," or "pre-standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 16,1993.

(13) "1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 16, 1993, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(14) "2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

(15) "Secretary" means the secretary of the United States Department of Health and Human Services. (History: 33-1-313, 33-22-904, MCA; IMP, 33-22-902, 33-22-903, 33-22-923, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.505 POLICY DEFINITIONS AND TERMS (1) No insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this rule and 33-22-903, MCA.

(2) The following definitions are in addition to those in 33-22-903, MCA:

(a) "Accident," "accidental injury," or "accidental means" must be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(i) The definition may not be more restrictive than the following: "injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(ii) The definition may provide that injuries may not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) "Benefit period" or "Medicare benefit period" may not be defined more restrictively than as defined in the Medicare program.

(c) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" must not be described more restrictively than as defined in the Medicare program.

(d) "Health care expenses" means, for purposes of ARM 6.6.508, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(e) "Hospital" must be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the Medicare program.

(f) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended."

(g) "Medicare eligible expenses" means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable by Medicare.

(h) "Physician" must not be defined more restrictively than as defined in the Medicare program.

(i) "Sickness" must not be defined more restrictively than the following: "Sickness means illness or disease of an insured person." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.506 PROHIBITED POLICY PROVISIONS (1) Except for permitted preexisting condition clauses as described in ARM 6.6.510, 6.6.522, and ARM 6.6.507D(1)(a)(i) , no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(3) No Medicare supplement policy or contract or certificate in force in the state of Montana shall contain benefits which duplicate benefits provided by Medicare.

(4) Subject to ARM 6.6.507(1)(a)(iv) and (v):

(a) a Medicare supplement policy or certificate with benefits for outpatient prescription drugs in existence prior to January 1, 2006, must be renewed for current policyholders or certificateholders who do not enroll in Part D at the option of the policyholder or certificateholder;

(b) a Medicare supplement policy or certificate with benefits for outpatient prescription drugs may not be issued after December 31, 2005; and

(c) after December 31, 2005, a Medicare supplement policy or certificate with benefits for outpatient prescription drugs may not be renewed after the policyholder or certificateholder enrolls in Medicare Part D unless:

(i) the policy or certificate is modified to eliminate outpatient drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(ii) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable. (History: 33-1-313, 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.507 BENEFIT STANDARDS FOR MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010 (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) the following standards are in addition to all other requirements of this subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:

(i) a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involves a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(ii) a Medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(iii) A Medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes;

(iv) no Medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium;

(v) each Medicare supplement policy shall be guaranteed renewable and:

(A) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

(vi) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(a)(viii), the issuer must offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(A) provides for continuation of the benefits contained in the group policy; or

(B) provides for such benefits as are required to meet the minimum standards as defined in 6.6.507D(4)];

(vii) if an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(A) offer the certificateholder the conversion opportunity described in (1)(a)(vi);

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;

(viii) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(ix) if a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the modified policy or certificate shall be deemed to satisfy the guaranteed renewal requirements of this rule.

(2) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(3) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims.

(a) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period.

(b) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled

to benefits under 226(b) of the Social Security Act and is covered under a group health plan (as defined in 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of loss;

(c) Reinstitution of coverages as described in (3)(a) and (b); must

(i) not provide for any limitation period with respect to treatment of preexisting conditions;

(ii) provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy or certificate for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(4) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her pre-standardized plan or 1990 standardized plan to a 2010 standardized plan as described in ARM 6.6.507E, the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a pre-standardized plan or a 1990 standardized policy or certificate with an issue age rate 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner for approval as part of the rate filing;

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage;

(c) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged pre-standardized plan or 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy; and

(d) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or Federal law.

(5) Standards for basic ("core") benefits common to benefit Plans A through J include the following:

(a) every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof:

(i) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(ii) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(iii) upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for the balance;

(iv) coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(v) coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the co-payment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(b) The following additional benefits must be included in Medicare supplement benefit Plans B through J only as provided by ARM 6.6.507A:

(i) coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;

(ii) coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

(iii) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(iv) coverage for 80% of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(v) coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(vi) coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy or certificate until January 1, 2006;

(vii) coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy or certificate until January 1, 2006;

(viii) coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" shall mean care

needed immediately because of an injury or an illness of sudden and unexpected onset; and

(ix) coverage for the following preventive health services not covered by Medicare:

(A) an annual clinical preventive medical history and physical examination that may include tests and services from (4)(b)(ix)(B) and patient education to address preventive health care measure;

(B) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

(C) reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120.00 annually under this benefit. This benefit must not include payment for any procedure covered by Medicare;

(x) coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) for purposes of this benefit, the following definitions apply:

(I) "activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(B) for the purposes of this benefit, the following coverage requirements apply:

(I) at-home recovery services provided must be primarily services which assist in activities of daily living.

(II) the insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40.00 per visit;

(III) $1,600.00 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this rule;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit;

(D) coverage is excluded for:

(I) home care visits paid for by Medicare or other government programs; and

(II) care provided by family members, unpaid volunteers or providers who are not care providers.

(c) the following are the standards for plans K and L:

(i) Standardized Medicare Supplement Benefit Plan K must consist of the following benefits:

(A) coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(E) coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(F) coverage for 50% of cost sharing for all Part A Medicare eligible expenses for hospice and respite care until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(G) coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(H) except for coverage provided in (4)(c)(i)(I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(I) coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. department of health and human services;

(ii) Standardized Medicare Supplement Benefit Plan L must consist of the following:

(A) the benefits described in (4)(c)(i)(A), (B), (C) and (I);

(B) the benefits described in (4)(c)(i)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and

(C) the benefits described in (4)(c)(i)(J), but substituting $2,000.00 for $4,000.00. (History: 33-1-313, 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2000 MAR p. 3518, Eff. 12/22/00; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.507A STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1993, AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010 (1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as established in ARM 6.6.507.

(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in (7) and Medicare select policies or certificates.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit Plans A through L listed in this rule and conform to the definitions in 33-22-903, MCA, and ARM 6.6.505. Each benefit shall be structured in accordance with the format provided in ARM 6.6.507(4)(a), (b), and (c) and list the benefits in the order shown in this rule. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(4) An issuer may use, in addition to the benefit plan designations required in (3), other designations to the extent permitted by law.

(5) The following descriptions detail the contents of the standardized benefit Plans A through J:

(a) Standardized Medicare Supplement Benefit Plan A must be limited to the basic ("core") benefits common to all benefit plans, as established in ARM 6.6.507(4).

(b) Standardized Medicare Supplement Benefit Plan B must include only the following:

(i) the core benefit as established in ARM 6.6.507(4), plus the Medicare Part A deductible as established in ARM 6.6.507(4)(b)(i).

(c) Standardized Medicare Supplement Benefit Plan C must include only the following:

(i) the core benefit, as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(b)(i), (ii), (iii), and (viii).

(d) Standardized Medicare Supplement Benefit Plan D must include only the following:

(i) the core benefit, as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as established in ARM 6.6.507(4)(b)(ii), (viii), and (x).

(e) Standardized Medicare Supplement Benefit Plan E must include only the following:

(i) the core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in ARM 6.6.507(4)(b)(ix).

(f) Standardized Medicare Supplement Benefit Plan F must include only the following:

(i) the core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(b).

(g) Standardized Medicare Supplement Benefit High Deductible Plan F shall include only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses include:

(A) the core benefit as defined in ARM 6.6.507; plus

(B) the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507(4)(b)(i), (ii), (iii), (v), and (viii);

(ii) The annual High Deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible shall be $1500.00 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.00.

(h) Standardized Medicare Supplement Benefit Plan G must include only the following:

(i) core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as established in ARM 6.6.507(4)(b)(i), (ii), (iv), (viii), and (x).

(i) Standardized Medicare Supplement Benefit Plan H must include only the following:

(i) the core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(b)(i), (ii), (vi), and (viii).

(iii) the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(j) Standardized Medicare Supplement Benefit Plan I must include only the following:

(i) the core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as established in ARM 6.6.507(4)(b)(i), (ii), (v), (vi), (viii), and (x).

(iii) the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(k) Standardized Medicare supplement benefit plan J must include only the following:

(i) the core benefit as established in ARM 6.6.507(4); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as established in ARM 6.6.507(4)(b)(i), (ii), (iii), (v), (vii), (viii), (ix), and (x).

(iii) the outpatient prescription drug benefit shall not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(l) Standardized Medicare Supplement Benefit High Deductible Plan J shall consist of only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan J deductible. The covered expenses include:

(A) the core benefit as defined in ARM 6.6.507; plus

(B) the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in ARM 6.6.507(4)(b)(i), (ii), (iii), (v), (vii), (viii), (ix), and (x);

(ii) The annual High Deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500.00 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.00.

(iii) the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(6) The following descriptions detail the contents of two Medicare supplement plans mandated by the MMA:

(a) standardized Medicare Supplement Benefit Plan K must consist of only those benefits described in ARM 6.6.507(4)(c)(ii); and

(b) standardized Medicare Supplement Benefit Plan L must consist of only those benefits described in ARM 6.6.507(4)(c)(ii).

(7) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit. (History: 33-1-313, 33-22-904, MCA; IMP, 33-22-902, 33-22-904, 33-22-905, MCA; NEW, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.507B OPEN ENROLLMENT (1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted prior to or during the six-month period beginning with the first day of the first month

in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy or certificate currently available from an issuer must be made available to all applicants who qualify under this rule without regard to age.

(2) If an applicant qualifies under ARM 6.6.507B(1) and submits an application during the time period referenced in (1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(3) If the applicant qualifies under ARM 6.6.507B(1) and submits an application during the time period referenced in (1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this rule.

(4) This rule must not be construed as preventing the exclusion of benefits under a policy, except as provided in (2) and (3) and ARM 6.6.507C and 6.6.522 during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective. (History: 33-1-313, 33-22-904, 33-22-905, MCA; IMP, 33-22-902, 33-22-904, MCA; NEW, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.507C GUARANTEED ISSUE FOR ELIGIBLE PERSONS (1) The following are general provisions relating to guaranteed issue:

(a) Eligible persons are those individuals described in (2) who enroll under the policy during the period specified in (3) and who submit evidence of the date of termination, disenrollment, or Medicare part D enrollment with the application for a Medicare supplement policy.

(b) with respect to eligible persons, an issuer shall not:

(i) deny or condition the issuance or effectiveness of a Medicare supplement policy described in (5) that is offered and is available for issuance to new enrollees by the issuer;

(ii) discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) if an eligible person who originally purchased an issue-age rated plan and then applies for another issue-age plan from any issuer on a guaranteed issue basis, that issuer must rate the replacement policy or certificate using the age at which the original policy or certificate being replaced was rated.

(2) An eligible person is an individual described in any of the following paragraphs:

(a) The individual is enrolled under an employee welfare benefit plan that:

(i) provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or

(ii) is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan;

(b) the individual is enrolled with a Medicare advantage organization under a Medicare advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare advantage plan:

(i) the organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(iii) the individual demonstrates, in accordance with guidelines established by the secretary, that:

(A) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(B) the organization, or agent or other entity on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(C) the individual meets such other exceptional conditions as the secretary may provide.

(c) The individual is enrolled with:

(i) one of the following organizations:

(A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) an organization under an agreement under section 1833(1)(A) of the Social Security Act (health care prepayment plan); or

(D) an organization under a Medicare select policy; and

(ii) the enrollment ceases under the same circumstance that would permit discontinuance of an individual's election of coverage under (2)(b).

(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(i) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) of other involuntary termination of coverage or enrollment under the policy;

(iii) the issuer of the policy substantially violated a material provision of the policy; or

(iv) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e) The individual was enrolled under a Medicare supplement policy and terminates enrollment and:

(i) subsequently enrolls, for the first time, with any Medicare advantage organization under a Medicare advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare select policy; and

(ii) the subsequent enrollment under (2)(e) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Federal Social Security Act); or

(f) the individual, upon first becoming eligible for benefits under Medicare part A at age 65, enrolls in a Medicare advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(g) the individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in (5)(e).

(3) The following describes the guaranteed issue time periods in the case of:

(a) an individual described in (2)(a), the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

(ii) the date that the applicable coverage terminates or ceases; and

(iii) ends 63 days after the applicable notice;

(b) an individual described in (2)(b), (c), (e) or (f) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(c) an individual described in (2)(d)(i), the guaranteed issue period begins on the earlier of:

(i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any; and

(ii) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated;

(d) an individual described in (2)(b), (d)(ii), (d)(iii), (e) or (f) who disenrolls voluntarily, the guarantee issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date;

(e) an individual described in (2)(g), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60 day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

(f) an individual described in (2) but not described in the preceding provisions of the rule, the guarantee issue period begins on the effective dates of disenrollment and ends on the day that is 63 days after the effective date.

(4) The following describes the guarantee issue time periods for extended Medicare supplement and Medicare select access for interrupted trial periods in the case of:

(a) an individual described in (2)(e) (or deemed to be so described, pursuant to this subsection) whose enrollment with an organization or provider described in (2)(e)(i) is involuntarily terminated with the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in (2)(e);

(b) an individual described in (2)(f) (or deemed to be so described, pursuant to this subsection) whose enrollment with a plan or in a program described in (2)(f) is involuntarily terminated with the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in (2)(f); and

(c) for purposes of (2)(e) and (f), no enrollment of an individual with an organization or provider described in (2)(e)(i), or with the plan or in a program described in (2)(f), may be deemed to be an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(5) The following describe the type of Medicare supplement policy which must be issued to an eligible person:

(a) an eligible person defined in (2)(a), (b), (c), or (d) is entitled to the issuance of a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer;

(b) subject to (5)(c), an eligible person defined in (2)(e) is entitled to the issuance of the same Medicare supplement policy in which the eligible person was most recently enrolled, if available from the issuer, or, if not so available, a policy described in (5)(a);

(c) after December 31, 2005, an individual who was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit and who elects to enroll in Part D, is entitled to the issuance of a Medicare supplement policy described as follows:

(i) the same policy from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, an A, B, C, F (including F with high deductible), K, or L policy that is offered by any issuer;

(d) an eligible person defined in (2)(f) is entitled to the issuance of any Medicare supplement policy offered by any issuer;

(e) An eligible person defined in (2)(g) is entitled to the issuance of a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. However, if the eligible person wishes to enroll in an A, B, C, F (including high deductible F), K, or L and that issuer does not offer that plan, then the eligible person is entitled to have that plan issued by any issuer who makes it available for sale to new enrollees in Montana.

(6) The following establish standards for notification upon termination and disenrollment:

(a) at the time of an event described in (2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this rule, and of the obligations of issuers of Medicare supplement policies under (1). Such notice shall be communicated contemporaneously with the notification of termination.

(b) at the time of an event described in (2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis of the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this rule, and of the obligations of issuers of Medicare supplement policies under (1). Such notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment. (History: 33-1-313, 33-22-904, 33-2-905, MCA; IMP, 33-22-902, 33-22-904, and 33-22-905, MCA; NEW, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1910, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

ARM 6.6.507D BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010 (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate with an effective date for coverage on or after June 1, 2010, unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement Benefit Plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507 and other applicable rules and statutes contained in this subchapter and Title 33, chapter 22, part 9, MCA.

(a) The following standards are in addition to all other requirements of this subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:

(i) a Medicare supplement policy or certificate must not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involves a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(ii) a Medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(iii) a Medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes;

(iv) no Medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium;

(v) each Medicare supplement policy shall be guaranteed renewable and:

(A) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(vi) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(a)(viii), the issuer must offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(A) provides for continuation of the benefits contained in the group policy; or

(B) provides for such benefits that meet the requirements of this subsection.

(vii) if an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(A) offer the certificateholder the conversion opportunity described in (1)(a)(vi); or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(viii) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(2) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(3) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims:

(a) if such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of the termination of entitlement;

(b) each Medicare supplement policy or certificate must provide that benefits and premiums under the policy must be suspended (for any period that may be

provided by Federal regulation) at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under 226(b) of the Social Security Act and is covered under a group health plan (as defined in 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of loss of coverage;

(c) reinstitution of coverages as described in (3)(a) and (b) must:

(i) not provide for any limitation with respect to treatment of preexisting conditions;

(ii) provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(4) Standards for basic ("core") benefits common to benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N include the following:

(a) every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof:

(i) coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(ii) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(iii) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv) coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations;

(v) coverage for the coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

(vi) coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(b) The following additional benefits must be included in Medicare Supplement Benefit Plans B, C, D, F, and F with High Deductible, G, M, and N as provided by ARM 6.6.507E:

(i) coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period;

(ii) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period;

(iii) coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

(iv) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(v) coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

(vi) coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. (History: 33-1-313, 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.507E STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010 (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507A.

(2) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as established in ARM 6.6.507D(4).

(3) If an issuer makes available any of the additional benefits described in ARM 6.6.507D(4)(b) or offers standardized benefits Plans K or L (as described in ARM 6.6.507E(8)(a) and (b) of this subchapter, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as describe in (2), a policy form or certificate form containing either Standardized Benefit Plan C (as described in ARM 6.6.507E(7)(c) of this subchapter) or Standardized Benefit Plan F (as described in ARM 6.6.507E(7)(e) of this subchapter.

(4) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in ARM 6.6.507E(11) and ARM 6.6.601-614 of these rules.

(5) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this rule and conform to the definitions in 33-22-903, MCA, and ARM 6.6.505. Each benefit shall be structured in accordance with the format provided in ARM 6.6.507D(4)(a) and (b); or in the case of Plans K or L, in ARM 6.6.507E(8)(a) and (b), and list the benefits in the order

shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

(6) An issuer may use, in addition to the benefit plan designations required in (5), other designations to the extent permitted by law.

(7) The following descriptions detail the contents of the 2010 standardized benefit plans:

(a) Standardized Medicare Supplement Benefit Plan A must be limited to the basic ("core") benefits common to all benefit plans, as established in ARM 6.6.507D(4)(a);

(b) Standardized Medicare Supplement Benefit Plan B must include only the following:

(i) the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible as established in ARM 6.6.507D(4)(b).

(c) Standardized Medicare Supplement Benefit Plan C must include only the following:

(i) the core benefit, as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(d) standardized Medicare Supplement Benefit Plan D must include only the following:

(i) the core benefit, as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as established in ARM 6.6.507D(4)(b).

(e) Standardized Medicare Supplement Benefit regular Plan F must include only the following:

(i) the core benefit as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(f) standardized Medicare Supplement Benefit High Deductible Plan F shall include only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses include:

(A) the core benefit as defined in ARM 6.6.507D(4)(a); plus

(B) 100% of the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b);

(ii) The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement regular Plan F policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1500 and shall be adjusted annually from 1999 by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(g) Standardized Medicare Supplement Benefit Plan G must include only the following:

(i) core benefit as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(8) The following descriptions detail the contents of two Medicare supplement plans authorized by the MMA:

(a) Standardized Medicare Supplement Benefit Plan K must consist of only the following benefits:

(i) coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st day through the 90th day in any Medicare benefit period;

(ii) coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(iii) upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for the balance;

(iv) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (x);

(v) coverage for 50% of the coinsurance amount for each day used for the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (x);

(vi) coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (x);

(vii) coverage for 50%, under Medicare Part A or B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in (x);

(viii) except for coverage provided in (ix) of this subsection, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Part B deductible until the out-of-pocket limitation is met as described in (x);

(ix) coverage of 100% of the cost sharing for Medicare Part B preventative services after the policyholder pays the Part B deductible; and

(x) coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(b) Standardized Medicare Supplement Benefit Plan L must consist of only the following benefits:

(i) the benefits described in (8)(a)(i), (ii), (iii), and (ix);

(ii) the benefit described in (8)(a)(iv), (v), (vi),(vii) and (viii), but substituting 75% for 50%; and

(iii) the benefit described in (8)(a)(x), but substituting $2000 for $4000.

(9) Standardized Medicare Supplement Plan M shall include only the following:

(a) the basic core benefit as defined in ARM 6.6.507D(4)(a), plus 50% of the Medicare Part A deductible;

(b) skilled nursing facility care, and

(c) medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b).

(10) Standardized Medicare Supplement Plan N shall include only the following:

(a) the basic core benefit as defined in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible;

(b) skilled nursing facility care; and

(c) medically necessary emergency care in a foreign country as defined in ARM 6,6,507D(4)(b), with copayments in the following amounts:

(i) the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialist); and

(ii) the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, the copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(11) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits must include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, are cost-effective, and are offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits must not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. (History: 33-1-313, 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) A Medicare supplement policy form or certificate form must:

(a) not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) at least 75% of the aggregate amount of premiums earned in the case of group policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices;

(ii) at least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices; or

(iii) incurred health care expenses where coverage is provided by a health maintenance organization must not include:

(A) home office and overhead costs;

(B) advertising costs;

(C) commissions and other acquisition costs;
(D) taxes;
(E) capital costs;
(F) administrative costs; and
(G) claims processing costs.

(b) all filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(c) for purposes of this rule, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including print, broadcast, and electronic advertising) must be regarded as group policies; and

(d) for policies issued prior to September 30, 1993, expected claims in relation to premiums shall meet:

(i) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(ii) the appropriate loss ratio requirement from (1)(a)(i) and (ii) when combined with actual experience beginning with June 21, 1996 to date; and

(iii) the appropriate loss ratio requirement from (1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

(2) An issuer shall collect and file with the commissioner by May 31 of each year:

(a) the data contained in the reporting form contained in Appendix A of the NAIC Model Regulation To Implement The NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001 (see ARM 6.6.524), for each type in a standard Medicare supplement benefit plan;

(b) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation (see ARM 6.6.524) must be done on a statewide basis for each type in a standard Medicare Supplement Benefit Plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded;

(c) for the purposes of this subsection, for policies or certificates issued prior to September 30, 1993, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after February 13, 2004. The first report shall be due by May 31, 2005; and

(d) a refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) An issuer of Medicare supplement policies and certificates issued before or after the effective date of these rules in this state must file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner,

demonstrating that it is in compliance with the foregoing. The supporting documentation must also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

(a) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in the state must file with the commissioner, in accordance with the applicable filing procedures of this state:

(i) appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment must accompany the filing. An issuer must make such premium adjustments as are necessary to produce and expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(ii) an issuer must make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(A) the experience used to calculate an expected loss ratio must be the separate experience of any plan. If there is more than one Plan H, I, or J because of the requirements of the MMA, the experience of each plan issued before September 9, 2005, and of each H, I, or J Plan of any type issued on or after this date must be combined for the purpose of determining the expected loss ratio. The experience must also be provided separately for each of these plans for the department's records.

(iii) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule; and

(b) any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(4) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable

loss ratio standard. Any such determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner. (History: 33-1-313, 33-22-904, 33-22-906, MCA; IMP, 33-15-303, 33-22-902, 33-22-906, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 2000 MAR p. 3518, Eff. 12/22/00; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.508A FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) An issuer may not deliver, or issue for delivery, a policy or certificate to a resident of this state unless the policy form or certificate has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(a) An issuer's name must be as prominently displayed as the name of the association, tradename, or other sponsoring organization.

(b) The policy and certificate must be identified by the proper plan designation letter which must be included anywhere in the form number for the policy.

(2) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA, only with the commissioner in the state in which the policy or certificate was issued.

(3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation, together with the outline of coverage, have been filed with and approved by the commissioner in accordance with the filing requirements and procedures by the commissioner.

(4) Except as provided in (4)(a), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare Supplement Benefit Plan.

(a) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(i) the inclusion of new or innovative benefits;

(ii) the addition of either direct response or agent marketing methods;

(iii) the addition of either guaranteed issue or underwritten coverage;

(iv) the offering of coverage to individuals eligible for Medicare by reason of disability.

(b) For the purposes of this rule, a "type" means an individual policy, a group policy, an individual Medicare select policy, or a group Medicare select policy.

(5) Except as provided in (5)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to (5)(a) may not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(c) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(d) Any change in the rating structure or methodology shall be considered a discontinuance under (5) unless the issuer complies with the following requirements:

(i) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest; and

(iii) The issuer applies the revised rating methodology to in force business as well as to new business. The issuer must refund the difference between the total amount of premium each insured individual actually paid under the existing rating methodology and the total amount of premium the individual would have paid if the revised rating methodology had been applied since the issue date of that individual's coverage, if the difference is greater than zero dollars. The refund process must be carried out in a form and manner prescribed and approved by the commissioner.

(6) Except as provided in (6)(a), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in ARM 6.6.508.

(a) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(7) An issuer may not file a rate structure for its Medicare supplement policies and certificates after January 1, 2006, based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages must exhibit a smooth pattern as age increases. (History: 33-1-313, 33-22-904, 33-22-905, 33-22-906, MCA; IMP, 33-22-904, 33-22-906, MCA; NEW, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1910, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract to be issued. The provision must be appropriately captioned, must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to

avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing and signed by the insured, unless the increased benefits or coverage are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy.

(3) Medicare supplement policies or certificates must not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".

(5) Medicare supplement policies and certificates must have notices prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare must provide to such applicants a Medicare supplement "buyer's guide". This may be the pamphlet entitled "Guide to Health Insurance for People with Medicare," developed jointly by the national association of insurance commissioners and the center for Medicaid and Medicare services (CMS) of the U.S. Department of Health and Human Services, or any reproduction or official revision of that pamphlet in a type size no smaller than 12 point type. The "buyer's guide" must conform to the language, format, type size, type proportional spacing, bold character, and line spaces as specified in Appendix C of the NAIC Model Regulation (see ARM 6.6.526).

(a) Delivery of the "buyer's guide" must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgment of receipt of the "buyer's guide" must be obtained by the issuer. Direct response issuers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

(7) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice must:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare;

(c) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and concise terms so as to facilitate comprehension; and

(d) Such notices must not contain, or be accompanied by, any solicitation.

(8) Issuers shall comply with any notice requirements of the MMA.

(9) Issuers shall provide an outline of coverage to each applicant at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant:

(a) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point bold type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(b) The outline of coverage provided to applicants consists of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than 12 point type. All plans must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

(c) The following items must be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: 1 of 2

Benefit Plan(s)____[insert letter(s) of plan(s) being offered]

These charts show the benefits included in each of the 1990 standardized Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in your state. New 1990 standardized benefit plans may not be issued on or after June 1, 2010.

See Outline of Coverage sections for details about ALL plans

Basic Benefits for Plans A-J:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits

		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT covered by Medicare

F	F*	G	H	I	J	J*
Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
Part B Deductible					Part B Deductible	
Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
		At-Home Recovery		At-Home Recovery	At-Home Recovery	
					Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $2000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]

Outline of Medicare Supplement Coverage - Cover Page 2

Basic Benefits for Plans K and L: include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4620] Out of Pocket Annual Limit***	$[2310] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plan A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

Benefit Chart of Medicare Supplement Plans Sold with an effective date for coverage on or after June 1, 2010.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	50% Part A Deductible	50% Part A Deductible	50% Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

(10) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under section 1876 or section 1833 of the Federal Social Security Act (42 USC Sec. 1395, et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in ARM 6.6.503(2) issued for delivery in this state to persons eligible for Medicare by reason of age must be accompanied by a notice to the insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice must either be printed on or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice must be in no less than 12 point type and must contain the following language: "THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the company."

(11) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in this rule shall disclose, using the applicable statement in Appendix C of the NAIC Model Regulation, which was incorporated by reference in ARM 6.6.519, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate. (History: 33-1-313, 33-22-904, 33-22-907, MCA; IMP, 33-15-303, 33-22-902, 33-22-904, 33-22-907, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2000 MAR p. 3518, Eff. 12/22/00; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare advantage, Medicaid coverage, or another health policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements as the following may be used:

(a) (STATEMENTS)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy must be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid,

at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(b) (QUESTIONS)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark yes or no below with an "X"]

To the best of your knowledge:

(1)(a) Did you turn age 65 in the last 6 months? YES ____ NO ____

(b) Did you enroll in Medicare Part B in the last 6 months? YES ___ NO ___

(c) If yes, what is the effective date? _____

(d) Did you enroll in Medicare Part C in the last 6 months? YES ___ NO ___

(e) If yes, what is the effective date? _____

(f) Did you enroll in Medicare Part D in the last 6 months? YES ___ NO ___

(g) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program? [NOTE TO APPLICANT: If you are participating in a "spend-down" program and have not met your "share of cost," please answer NO to this question.] YES ___ NO ___ If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? YES ___ NO ___

(b) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? YES ___ NO ___

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start ___/___/___ End ___/___/___/

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? YES ___ NO___

(c) Was this your first time in this type of Medicare plan? YES ___ NO ___

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? YES ___ NO ___

(4)(a) Do you have another Medicare supplement policy in force? YES ___ NO ___

(b) If so, with what company, and what plan do you have [optional for direct mailers]?_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? YES ___ NO ___

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) YES ___ NO ___

(a) If so, with what company and what kind of policy? _____
_____
_____
_____

(b) What are your dates of coverage under the other policy? Start ___/___/___ End ___/___/___/ (If you are still covered under the other policy, leave "end" blank.)

(6) Producers shall list any other health insurance policies they have sold to the applicant, including:

(a) Policies sold which are still in force.

(b) Policies sold in the past five years which are no longer in force.

(7) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(8) Upon determining that a sale will involve replacement of Medicare supplement coverage, and prior to the issuance or delivery of the Medicare supplement policy or certificate, an issuer, other than a direct response insurer, or its producer must furnish the applicant a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the producer, except where coverage is sold without a producer, must be provided to the applicant and an additional signed copy must be retained by the issuer for three years. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(9) The notice required by (4) for an issuer must be in substantially the same form as below and be in no less than 12 point type.

(c) NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

(Insurance Company's Name and Address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing Medicare or Medicare advantage supplement insurance and replace it with a policy to be issued by (Company Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement or Medicare advantage coverage is a wise decision. STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan.–The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.
_____ No change in benefits, but lower premiums.
_____ Fewer benefits and lower premiums.
_____ Other. (please specify)
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [optional only for direct mailers.]

_____
_____
_____

(1) Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement (2) below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it

carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Producer or Other Representative)*

_____

[Typed Name and Address of Issuer or Producer]

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

Applicant's Signature)

*Signature not required for direct response sales.

**Paragraphs (1) and (2) of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. (History: 33-1-313, 33-22-904, 33-22-907, MCA; IMP, 33-15-303, 33-22-904, 33-22-907, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 1/1/97; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1910, Eff. 9/9/05.)

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, for services furnished in the current calendar year under Medicare's hospital insurance program (Medicare Part A), must apply to the charts for 1990 Plans A through L for policies issued prior to June 2010 in (2)(b) through (m). In each chart, the rule cited in brackets as ARM [6.6.511(1)(a)], [6.6.511(1)(b)], [6.6.511(1)(c)], [6.6.511(1)(d)], [6.6.511(1)(e)], [6.6.511(1)(f)], [6.6.511(1)(g)], [6.6.511(1)(h)], [6.6.511(1)(i)], or [6.6.511(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

(a) inpatient hospital deductible = $1068.00;

(b) benefit period = $267.00;

(c) daily coinsurance amount for the 61st through 90th days of hospitalization in a coinsurance amount for lifetime reserve days = $534.00;

(d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $133.50;

(e) 50% of inpatient hospital deductible = $534.00;

(f) 75% of inpatient hospital deductible = $801.00;

(g) 25% of inpatient hospital deductible = $267.00;

(h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $66.75;

(i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $100.13; and

(j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $33.38.

(2) The following are sample forms of the outline of coverage for Medicare supplement policies.

(a) COVER PAGE

PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.
This outline shows benefits and premiums of policies sold for effective dates prior to June 1, 2010.

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(b) PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			$[6.6.511(1)(a)] (Part A deductible)
First 60 days	All but $[6.6.511(1)(a)]	$0	
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	$0	Up to $[6.6.511(1)(d)] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
--First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
--Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare ---approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare ---approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
---First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
---Remainder of Medicare approved amounts	80%	20%	$0

(c) PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	$0	Up to $[6.6.511(1)(d)] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

(d) PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment	100%	$0	$0
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(e) PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT YEAR

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(a)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(f) PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies		$[6.6.511(1)(a)]	
First 60 days	All but $[6.6.511(1)(a)]	(Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:		100% of Medicare	
---Additional 365 days	$0	eligible expenses	$0**
---Beyond the additional 365 Days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
21st thru 100th day 101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER BENEFIT PERIOD

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICARE CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(g) PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATON* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but [6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. [**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
---Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(h) PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	**YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve ---days are used: ---Additional 365 days	$0	100% Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan ---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(i) PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All but	$[6.6.511(1)(a)]	
First 60 days	$[6.6.511(1)(a)]	(Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used: ---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved		
First 20 days	amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)]a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN H

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(j) PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(k) PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[2000] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO [$2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[**This high deductible plan pays the same as plan J after one has paid a calendar year $[2000] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0		$0
Next $[135] of Medicare approved amounts*	$0	All costs $[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	$0	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
HOME HEALTH CARE AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN J or HIGH DEDUCTIBLE PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

***Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(l) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (50% of Part A deductible)	$[6.6.511(1)(e)]♦
61st thru 90th day	All but [6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(h)] a day	Up to $[6.6.511(1)(h)]♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%♦ $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)****
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)****♦
Remainder of Medicare Approved amounts	Generally 80%	Generally 10%	Generally 10%
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*****	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	10%	10%

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare

(m) PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with a diamond (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does not include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(f)] (75% of Part A deductible)	$[6.6.511(1)(g)] 25% of Part A deductible♦
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

PLAN L

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(i)] a day	Up to $[6.6.511](1)(j)] a day♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts****	$0	$0	$[135] (Part B deductible)****♦
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[135] of Medicare approved amounts****	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*****	$0	$0	$[135] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	15%	5%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1997 MAR p. 1818, Eff. 10/7/97; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2004 MAR p. 3014, Eff. 12/17/04; AMD, 2005 MAR p. 1910, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.511A SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, for services furnished in the current calendar year under Medicare's hospital insurance program (Medicare Part A), must apply to the charts for Plans A, B, C, D, F, and High Deductible Plan F, G, K, L, M, and N, issued on or after June 1, 2010, in (2)(b) through (m). In each chart, the rule cited in brackets as ARM [6.6.511A(1)(a)], [6.6.511A(1)(b)], [6.6.511A(1)(c)], [6.6.511A(1)(d)], [6.6.511A(1)(e)], [6.6.511A(1)(f)], [6.6.511A(1)(g)], [6.6.511A(1)(h)], [6.6.511A(1)(i)], or [6.6.511A(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

(a) inpatient hospital deductible = $1068.00;

(b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = $267.00;

(c) daily coinsurance amount for lifetime reserve days = $534.00;

(d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $133.50;

(e) 50% of inpatient hospital deductible = $534.00;

(f) 75% of inpatient hospital deductible = $801.00;

(g) 25% of inpatient hospital deductible = $267.00;

(h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $66.75;

(i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $100.13; and

(j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $33.38.

(2) The following are sample forms of the outline of coverage for Medicare supplement policies:

(a) COVER PAGE

PREMIUM INFORMATION [boldface type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J, are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [boldface type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(b) PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$0	$[6.6.511A(1)(a)] (Part A deductible)
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	$0	Up to $[6.6.511A(1)(d)] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
--First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
--Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare ---approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare ---approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
---First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
---Remainder of Medicare approved amounts	80%	20%	$0

(c) PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$[6.6.511A(1)(a)] (Part A	
First 60 days	All but $[6.6.511A(1)(a)]	deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	$0	Up to $[6.6.511A(1)(d)] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

(d) PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment	100%	$0	$0
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(e) PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT YEAR

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(a)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(f) PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATON* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but [6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare coinsurance/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135] of Medicare approved amounts*	$0	$[135] (Part B deductible)	$0
---Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(g) PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	**YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	$0 $0	100% Medicare eligible expenses $0	$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(h) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies		$[6.6.511A(1)(a)] (50% of Part A deductible)	
First 60 days	All but $[6.6.511A(1)(a)]		$[6.6.511A(1)(e)]♦
61st thru 90th day	All but [6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

PLAN K

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(h)] a day	Up to $[6.6.511A(1)(h)]♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)****
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)****♦
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*****	$0	$0	$[135] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare

(i) PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with a diamond (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does not include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(f)] (75% of Part A deductible)	$[6.6.511A(1)(g)] 25% of Part A deductible♦
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

PLAN L

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(i)] a day	Up to $[6.6.511A](1)(j)] a day♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment	25% of copayment/ coinsurance♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts****	$0	$0	$[135] (Part B deductible)****♦
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[135] of Medicare approved amounts****	$0	$0	$[135] (Part B deductible)♦
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*****	$0	$0	$[135] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	15%	5%♦

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(j) PLAN M

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies		$[6.6.511A(1)(e)] (50% of Part A deductible)	$[6.6.511A(1)(e)] (50% of Part A deductible)
First 60 days	All but $[6.6.511A(1)(a)]		
61st through 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drug and inpatient respite care	Medicare copayment/ Coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(k) PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st through 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drug and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-924, MCA; NEW, 2009 MAR p. 1107, Eff. 7/17/09.)

6.6.512 SEVERABILITY (REPEALED) (History: 33-1-313, MCA; IMP, 33-22-901 through 33-22-909, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.513 EFFECTIVE DATE (REPEALED) (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901 through 33-22-924, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.514 BENEFIT CONVERSION REQUIREMENTS DURING TRANSITION (REPEALED) (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901 through 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.515 STANDARDS FOR CLAIMS PAYMENT (1) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise. Any cost may not be passed on to the insured as a separate distinguishable charge and the charge may not be separated from the premium; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the above requirements must be certified on the Medicare supplement insurance experience reporting form. (History: 33-1-313, MCA; IMP, 33-11-901 through 33-22-909, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.516 FILING REQUIREMENTS FOR OUT-OF-STATE GROUP POLICIES (REPEALED) (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901 through 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.517 PERMITTED COMPENSATION ARRANGEMENTS (1) An issuer or other entity may provide commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

(3) No issuer or other entity shall provide compensation to its producers or other representatives and no producer or other representative shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(4) For purposes of this rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and service and finders fees.

(5) As part of the annual filing under ARM 6.6.508(3), the entity providing Medicare supplement policies shall provide copies of commission schedules. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-902, 33-22-904, 33-22-906, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487. Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 1/1/97; AMD, 2004 MAR p. 1017, Eff. 2/13/04.)

6.6.518 FILING REQUIREMENTS FOR ADVERTISING (REPEALED) (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901 through 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; REP, 1993 MAR p. 1487, Eff. 7/16/93.)

6.6.519 STANDARDS FOR MARKETING (1) An issuer directly or through its producers shall:

(a) establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

(b) establish marketing procedures to assure excessive insurance is not sold or issued;

(c) establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits greater than the benefits under the replaced policy;

(d) display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses;"

(e) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance;

(f) establish auditable procedures for verifying compliance with this rule; and

(g) provide to the enrollee an appropriate disclosure statement if the enrollee has accident and sickness insurance. These statements must be identical to the disclosure statements in Appendix C of the NAIC Model Regulation To Implement The NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001, (see ARM 6.6.526).

(2) In addition to the practices prohibited in Title 33, chapter 18, MCA, the following acts and practices are prohibited:

(a) knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer;

(b) employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

(c) making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or issuer.

(3) The terms "medigap" and "Medicare wrap-around" must not be used. The terms "Medicare supplement" and "Medicare select" and words of similar import must not be used unless the policy or certificate is issued in compliance with applicable administrative rules and statutes. (History: 33-1-313, 33-18-235, 33-22-904, MCA; IMP, 33-15-303, 33-18-202, 33-18-204, 33-22-907, 33-22-908, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 1/1/97; AMD, 2004 MAR p. 313, Eff. 2/14/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.520 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE (1) In recommending the purchase or replacement of

any Medicare supplement policy or certificate, an insurance producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(3) An issuer may not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.521 REPORTING OF MULTIPLE POLICIES (1) On or before March 1 of each year, every issuer shall report, on the form contained in Appendix B of the NAIC Model Regulation To Implement The NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001, (see ARM 6.6.525), information for every individual resident of this state for which the issuer has in force more than one Medicare supplement insurance policy or certificate. The following information must be reported:

(a) policy and certificate number; and

(b) date of issuance.

(2) The items set forth above must by grouped by individual policyholder. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-904, 33-22-907, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 2156, Eff. 1/1/97; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.522 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS, AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy to the extent such time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy must not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods. (History: 33-1-313, 33-22-904, MCA; IMP, 33-15-303, 33-22-902, 33-22-904, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 2004 MAR p. 313, Eff. 2/13/04.)

6.6.523 SEPARABILITY (1) If any provision of this subchapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected. (History: 33-1-313, MCA; IMP, 33-22-902, MCA; NEW, 2004 MAR p. 313, Eff. 2/13/04.)

6.6.524 APPENDIX A - MEDICARE SUPPLEMENT REFUND CALCULATION FORM (1) This is the appendix referred to in ARM 6.6.508(2) and (3).

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes - 1a-1b		
2.	Past Year's Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)		
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception Tolerance	
10,000+	0.0%
5,000-9,999	5.0%
2,500-4,999	7.5%
1,000-2,499	10.0%
500-999	15.0%
If less than 500, no credibility.	

1. Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2. "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
3. Includes Modal Loadings and Fees Charged
4. Excludes Active Life Reserves
5. This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)] x Ratio 3 (line 11)
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)- [Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

(History: 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.525 APPENDIX B - FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES (1) This is the appendix referred to in ARM 6.6.521.

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

(History: 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.526 APPENDIX C DISCLOSURE STATEMENTS (1) This is the appendix referred to in ARM 6.6.509(6).

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

(1) Section 1882(d) of the Federal Social Security Act (42 U.S.C. 1395ss) prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

(2) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(3) State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

(4) Property/casualty and life insurance policies are not considered health insurance.

(5) Disability income policies are not considered to provide benefits that duplicate Medicare.

(6) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

(7) The federal law does not preempt state laws that are more stringent than the federal requirements.

(8) The federal law does not preempt existing state form filing requirements.

(9) Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(a) [Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check for coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(b) [Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]

- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(c) [Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(d) [Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified

disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(e) [Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(f) [Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(g) [Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(h) [Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE INSURANCE

Some health care service paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(i) [Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(j) [Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(k) [Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(l) [Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization

- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(m) [Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(n) [Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(History: 33-22-904, 33-22-905, MCA; IMP, 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA; NEW, 2005 MAR p. 1672, Eff. 9/9/05.)

6.6.527 PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING (1) This subsection applies to all policies with policy years beginning on or after May 21, 2009. An issuer of a Medicare supplement policy or certificate shall not:

(a) deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and

(b) discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(2) Nothing in (1) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(a) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(b) increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(3) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(4) Section (3) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with (1).

(5) For purposes of carrying out (4), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(6) Notwithstanding (3), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) noncompliance will have no effect on enrollment status or premium or contribution amounts.

(c) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(d) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(e) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

(7) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(8) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(9) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of (8) if such request, requirement, or purchase is not in violation of (7).

(10) For the purposes of this section only:

(a) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer;

(b) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

(c) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual;

(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education;

(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

(f) "Underwriting purposes" means:

(i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) the computation of premium or contribution amounts under the policy;

(iii) the application of any preexisting condition exclusion under the policy; and

(iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. (History: 33-1-313, 33-22-904, MCA; IMP, 33-22-904, 33-18-901, 33-18-902, 33-18-903, 33-18-904, MCA; NEW, 2009 MAR p. 1107, Eff. 7/17/09.)